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Limiting Transgender Health: Administrative Violence and Microaggressions in Health Care Systems

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Health Care Disparities and the LGBT Population

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and Teresa Heinz Housel

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Limiting Transgender Health

Administrative Violence and Microaggressions in Health Care Systems

Sonny Nordmarken and Reese Kelly

Access to comprehensive, quality health care impacts an individual's physical, social, and mental health status, quality of life, and life expectancy. Barriers to access and inadequate or delayed services leave health care seekers with unmet health needs and decreased life expectancy (2012 National Health Care Disparities Report, 2013). Stigmatized groups often face compromised health care access as a result of structural inequality as well as unequal interpersonal treatment in medical systems in the United States. In particular, transgender people encounter numerous, multitiered obstacles when seeking health care. As we will illustrate, the process of obtaining health care itself can be particularly harmful to many trans people. Thus, they experience greater health risks, decreased life expectancies, and fewer opportunities to obtain necessary medical care than cisgender ("cis"), or nontransgender, people.

LITERATURE REVIEW

For trans people, disparities in access to health care result from legal, administrative, and social systems and practices that maintain a cis-normative culture, which privileges and normalizes cisgender experiences. Several factors contribute to this cis-normativity. First, identity documentation, which starts with sex classification at birth, reifies a two-sex paradigm. What Kelly (2012) calls "administrative recognition" occurs when administrative systems officially recognize trans people's identities. This type of recognition is imperative for health access, as it requires administrators to record trans people's identities accurately and consistently. Because administrative systems obstruct sex reclassification on

identity documents, trans individuals may lack valid identity documentation (Kelly; Namaste, 2000; Spade, 2011). This predicament renders them "impossible" (Spade), limiting their access to employment, public programs, and health care. At times when trans people do achieve administrative recognition, health care may remain inaccessible simply because it is unaffordable. As trans people face marriage and employment discrimination (and they are twice as likely to be unemployed as cis people), they are less likely to have financial resources or health insurance benefits (Flynn, 2006; Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011). They also face overt discrimination in health benefits systems. Many health insurance companies and almost half of state-sponsored public programs in the United States explicitly exclude coverage for transition-related health care (Gehi & Arkles, 2007). Additionally, both public and private benefits systems exclude undocumented trans immigrants, leaving them to navigate immigration law enforcement, legal mandates, and community-oriented health care services that may or may not be trans-inclusive (Heyman, Nunez, & Talavera, 2009). These institutional discriminatory practices amount to administrative violence (Spade).

In addition to structural barriers to access, inequities also manifest in the quality of health care trans people receive. Markedly, trans people who are able to access medical care commonly endure derogatory, negligent, or harmful treatment. Cissexism plays an important role in this problem. Although a wide range of populations experience mistreatment by health care providers, such as those who are HIV positive, poor, sex workers, fat, or non-English speaking, to name a few, mistreatment specific to trans individuals is rooted in the cissexist notions that sex and gender are binary and immutable categories, and that trans people lack the epistemological legitimacy and authority to authenticate their own sex and gender identities (Serano, 2007). Sexing individuals without consent at birth, requiring that a medical or legal administrator validates a person's sex in the reclassification process, and interpersonally acting as the arbiters of a trans person's "real" gender render cis people legitimate and trans people illegitimate gender authenticators (Kelly, 2012). In addition, cultural tropes represented in media maintain transphobic stereotypes, characterizing sex or gender shifts as strange, unnatural, fake, or monstrous (Serano). These erroneous, dehumanizing perceptions shape health care workers' behavior and take shape in microaggressions.

Microaggressions are everyday interpersonal communications that send negative messages to individuals on account of their perceived membership in or affiliation with a marginalized group (Sue, 2010). These messages are manifestations of oppression woven into the social fabric of ordinary life (Kitzinger, 2009). Whether conscious or not, all individuals enact microaggressions, many of which are routine, unintended, and invisible to both deliverers and recipi-

ents. They are verbal, nonverbal, and environmental, appearing in a range of articulations from facial expressions, body language, terminology, remarks, and representations, to the operation of institutionalized arrangements, such as rules and policies. The term "microaggression" is somewhat of a misnomer, as such actions, when examined individually, are not necessarily small or aggressive. Nevertheless, as these actions are repetitive, and at times are delivered en masse, they have great impact. Social distancing, dismissal, invalidation of a person's experience of reality, and indirect denigrating comments are nonaggressive kinds of microaggressions. Blatant discrimination, which is not "micro," can be understood as a form of microaggression if there is a possibility that perpetrators are unaware that their actions are derogatory or hurtful.

Sue (2010) created a microaggressions typology, which includes: microinsults, or unconscious and unintentional insulting communications; microinvalidations, which invalidate experiences of reality and discrimination; and microassaults, which are blatant and conscious. Applying Sue's typology, Nadal, Skolnik, and Wong (2012) describe twelve categories of microaggressions that trans people experience, including misgendering, universalizing of trans experience, exoticization, discomfort/disapproval, endorsement of gender normativity, denial of cultural transphobia, denial of one's own transphobia, sexual pathologization, physical threat or harassment, denial of privacy, familial microaggressions, and systemic and environmental microaggressions. As Kelly (2012) reminds us, "gender expressions and [trans bodies] are highly racialized and, as such, racial, national, and ethnic identities [and their associated dehumanizing stereotypes] become intertwined with any threat trans people pose as sex/gender 'others'" (p. 9; see also Gehi, 2009; Mogul, Ritchie, & Whitlock, 2011; Spade, 2011; Vidal-Ortiz, 2009). Thus, in addition to delivering transphobic, cis-normative and cissexist microaggressions, individuals may mobilize transphobia, cissexism, and cis-normativity as a basis for racist and racialized microaggressions.

Trans people commonly encounter microaggressions in a number of sites in their everyday lives, such as workplaces, religious venues, and public restrooms, and potentially from any individual they interact with, from family members to strangers (Kidd & Witten, 2008; Nadal et al., 2012). In this chapter, we expand on this discussion by examining the particular kinds of microaggressions trans people experience in health care systems. We define microaggressions as interactions that communicate "othering" messages, referencing gender nonconformity, that make transness an issue, or that cause trans people to feel self-conscious of their transness.

These often unintentional slights, snubs, or insults are embedded within a larger stream of communication. They can be confusing to receive and difficult to notice, pinpoint, or recognize, leaving them particularly challenging

to address, which can amplify the stress they cause. The negative impacts of microaggressions, such as chronic health problems, post-traumatic stress, or persistent anxiety, anger, depression, fear, hypervigilance, fatigue, shame, loneliness, and/or hopelessness (Pauly, 1990; Schrock, Boyd, & Leaf, 2007), are comparable to those caused by catastrophic traumas (Sue, 2010). In addition, as a result of their experiences with and knowledge about transphobic interactions and perhaps violence, trans people often anticipate these situations, amplifying their anxiety, hypervigilance, and fear (Kidd & Witten, 2008). These experiences of subjugation accumulate, creating a form of oppression-related stress, or what Meyer (1995) calls "minority stress."

As we have described, scholars have shown what administrative violence occurs structurally, on the macro-level, and on the micro-level, in interpersonal exchanges within health care settings and elsewhere. However, we do not know what meso-level, *institutional-interpersonal processes* take place to maintain the structural systems of inequality in which transgender people find themselves. This chapter explores these questions: How does cissexist social structure manifest on the interpersonal level in health care systems? How do social actors make use of institutional processes and norms to produce and reproduce trans inequality in health care systems, and what does this inequality look like? In the following pages, we address these questions.

The purposes of this chapter are: a) to chart common and interrelated microaggressions and blatant administrative violence that trans people experience in health care systems; b) to unpack the underlying meta-communications they carry; c) to explain when and how they happen; and d) to explain how social actors use institutional processes in health care to produce inequality between trans and cis people. As we will illustrate, the ways that health care providers often interact with trans patients in the midst of treatment create inadequate and inequitable services. This analysis will demonstrate how these mistreatments are rooted in cis-normative structural forces, administrative systems, and cultural practices that set up health care workers to mistreat trans people. We attempt to contextualize the impact as it relates to and is compounded by other structural variables that determine access to care including, but not limited to race, ethnicity, socioeconomic status, education, and nationality. Furthermore, in response to negligent, disrespectful, or damaging services, trans people labor to self-advocate, discontinue care, and/or seek care elsewhere. The cumulative effect of the cis-normative systems, ideologies, and behaviors on trans health seekers is an immeasurable reduction in access to and quality of care. We recommend working toward conscientious, trans-allied health care practices that will lead to greater health equity for trans people.

METHODS

This chapter combines ethnographic research from two separate projects on trans people's lives. One project investigated trans people's experiences receiving microaggressions in everyday interactions, and the other project investigated the strategies that trans people use when negotiating different social scenarios including sex-segregated facilities and identity document checkpoints. We draw on sixty-one semistructured, in-depth, and in-person interviews to examine the particular challenges that our participants faced navigating health care systems. We chose narratives from each project that described an interaction with medical providers to supplement, lend further evidence to, and nuance the findings from the other. Because both projects focused on social interactions, structural contexts, and individual agency, there was substantial overlap in what analytical themes emerged in the data and the conceptualization of root causes that shape trans lives.

For the first project, in 2011 and 2012, Nordmarken conducted participant observations and twenty-one semistructured interviews ranging from forty minutes to three hours with trans and gender-nonconforming people in northern California. Nordmarken also conducted participant observation in the Northeastern United States, and at four LGBTQ conferences, which took place in various regions of the United States. Perhaps this study could be viewed as conservative: One might expect that research on gender nonnormativity in relatively liberal, diverse places and contexts may underestimate the stigma at work in interaction. However, these sites still host cisgender norms that shape perception and inform interaction.

Nordmarken's study included people with a variety of gender identities, expressions, and experiences, such as transmasculine (female-to-male spectrum), transfeminine (male-to-female spectrum), and non- or multidirectional, such as genderqueer, gender nonconforming, or gender fluid. To get a sense of whether people who are different from each other experience similar responses to their gender nonconforming appearance (and they often do), Nordmarken interviewed people with various racial and ethnic identities, ages, education and income levels, and disabilities. However, a small sample cannot be systematically compared with experiences across populations. Nordmarken recruited five interviewees through personal networks, and fourteen through the use of social media. The strengths of snowball sampling are perhaps its limitations as well: It is effective at producing data about a specific community.

Nordmarken asked participants to describe their identity, everyday interactions in different places and contexts, instances in which their gender became an issue, and when and how they experienced recognition and misrecognition.

Nordmarken lived with an informant and interacted with others in phone conversations and digital communications, in private gatherings, and in public trans community spaces, such as political actions, religious services, LGBTQ Pride events, academic events, and art festivals—at least one hundred activities. Nordmarken wrote regular field notes and analytical memos, transcribed the audio recordings and open- and selectively coded the transcripts and the notes for themes, then analyzed the data in light of the literature.

For the second research project, Kelly conducted forty semistructured, in-depth and in-person interviews, ranging in length from seventy-five minutes to four hours, in the Northeastern United States between March and October 2009. Kelly recruited participants via online, print, and in-person communications. Although snowball sampling is the primary method of purposeful sampling when targeting nonnormative gender and sexual communities (see Mustanski, 2001; Shapiro, 2004), an online distribution of the advertisement and sampling from personal networks attracted a greater diversity of respondents with regards to age, race, disability, education, and nationality. Seventy-four individuals responded to the call for participants. Kelly chose forty that represented diversity across identity categories and compensated them $15 each for their participation; postoperative respondents were oversampled for comparative analyses. We use pseudonyms here to protect participants' confidentiality.

Kelly used a "theory-driven model of interviewing" where "the researcher's theory is the subject matter of the interview and the subject is to confirm or falsify, and above all, to refine that theory" (Pawson, 1996, p. 299). The initial questions in each interview covered demographic areas (see appendix), followed by questions that explicitly centered on the logics and strategies trans people use when negotiating their identities across four major areas: the use of identity documentation (e.g., driver's licenses and passports), the use of sex-segregated facilities (e.g., bathrooms and locker rooms), participation in gender-focused events or organizations, and in everyday life. Interviews followed a loose and repetitive script, allowing the researcher to play a more "explicit role in teaching the overall conceptual structure of investigation to the subject," and the participant "to agree, disagree and to categorize themselves in relation to the attitudinal patterns as constructed in such questions but also to refine their conceptual basis" (Pawson, p. 305). The overall effect was that participants were more actively engaged in the line of questioning and refined the project's conceptual basis. The transcripts were analyzed using a "multi-grounded theory" (Golkuhl & Cronholm, 2003) approach for themes and patterns of identity management in relation to gender identity and expression, bodily comportment, and documented identity, alongside other variables that were salient for the participant in each context such as race, ethnicity, nationality, and class.

As trans people in the cisgender-dominated world, and trans researchers in cisgender-dominated academe, we are what Patricia Hill Collins would call "outsiders within" (1986). To use Betsy Lucal's (1999) language, we have been both "socially male" and "socially female": We have been perceived and treated as male and female. However, our positions as trans researchers are from the standpoint of being both outsider as researcher and insider as trans (Dwyer & Buckle, 2009). We thus hold the status of insider-outsiders, unable to fully occupy either insider or outsider positions (Dwyer & Buckle). We have also, at times, been socially illegible and have encountered treatment in the ways those of us who embody gender nonconformity are treated. As our positionalities influence the knowledge we create (Mullings, 1999), our particular histories, contexts, and social locations shape the type of research we pursue and the data we generate: they are necessarily part of our narrative interpretation (Angrosino, 2005).

Notwithstanding, our trans statuses likely enhanced the access to participants; the comfort it may have given them may have produced "richer" data (Talbot, 1998–1999). However, interviewees who shared less in common with us may have been less inclined to reveal themselves. Although our familiarity with trans cultures and experience may enhance the depth to which we understand trans people and gendered processes, it may also limit our analysis. Certain things might seem less distinctive (Kanuha, 2000), and we may over-identify with participants (Glesne, 1999). It was important for us to, as Maykut and Morehouse (1994) suggest, acutely tune in to the activities we observed and the meanings that others made out of their experiences while also noticing how our perspectives can influence our perceptions and analyses. Nordmarken attempted, as Rose (1985) advises, to do his best to be aware of his biases, so that he could see how they shaped the data. At the same time, Nordmarken attempted to undermine the researcher-subject power dynamic and to view the process and the data as coproduced (Lloyd, Ennis, & Alkinson, 1994). Likewise, Kelly used a theory-driven interviewing approach (Pawson, 1996) to increase transparency and engage participants in coconstructing the interview.

RESULTS AND DISCUSSION

As we will illustrate, trans-specific microaggressions occur when dominant, cis-normative ways of thinking about gender and stereotypes about trans people actively manifest in social interaction. This can take shape in interactions when providers misunderstand or misinterpret trans people's identities, which invalidates the trans person's experiences of reality; when providers mispronoun or misname trans patients (using incorrect gender pronouns and

their former name), inquire about their "real" identity, and deny or fail to acknowledge their gender identity, pronouns, or name; and when providers express a perception that trans people are different from cis people. Providers may display behaviors that communicate discomfort, confusion, shock, distance, awkwardness, or dismissal. These are microaggressive behaviors because they express cissexist prejudice and send othering messages. Health care providers enact trans-specific microaggressions at various times: when they are aware of the patients' trans status, when they are not, or when they perceive a patient's gender to be unusual. In addition, as these stories reveal, providers' trans-specific microaggressions often accompany medical harm or neglect. In the following pages, we demonstrate how trans people experience pathologization, sexualization, rejection, invalidation, exposure, isolation, intrusion, and coercion at the hands of their caregivers.

Pathologization and Sexualization

Medical systems define gender identity diagnoses and treatments in definitively pathologizing and sexualizing ways. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-4; American Psychiatric Association, 2000) classifies trans identification and gender nonconformity as mental disorders, called "Gender Identity Disorder" (GID) and "Transvestic Fetishism." Although language in the fifth edition (DSM-5; American Psychiatric Association, 2013) characterizes GID primarily by a persistent discontinuity between one's sense of self and their body, previous editions of the DSM and foundational texts on transsexual and transvestite identity development use indicators of genital dissatisfaction, desire for a heterosexual postoperative lifestyle, and the eroticization of feminine clothing to characterize trans identities and experiences (Stryker, 2008). The institutionalization of transness as a mental health disorder characterized by diagnostic criteria that sexualize trans people's desires, practices, and body parts sets providers up to deliver pathologizing and sexualizing microaggressions.

Indeed, providers do deliver microaggressions. Oberon, a white and Cherokee trans man in his mid-forties, experienced overt pathologization from his primary care physician at Kaiser. This doctor, he shared, "reacted to my informing him that I was transitioning by referring me to a psychiatrist." This action was microaggressive because it sent a message to Oberon that his gender identity made him mentally disordered. In response to the referral, Oberon complained to his doctor: "I was like, I think you think you're following standards of care, but you are really out of date and really invasive." Here Oberon referred to the World Professional Association for Transgender Health's *Standards of care for the health of transsexual, transgender, and gender non-*

conforming people (2011), which guide providers in treating trans patients. These standards were originally published in 1979 and are periodically updated to reflect current recommended best practices. Currently, it is not appropriate to refer trans people to psychiatrists to enable them to medically transition. In addition, by suggesting that a psychiatrist should be introduced into the transition process, the practitioner communicated a cissexist assumption that trans people are not able to understand or determine their gender identity on their own. This microaggression is disempowering and insulting, as it places the authority of gender identity in the realm of mental health professionals rather than the realm of individual experiences. In response, Oberon became upset, sharing, "and fuck you very much. That's just not OK with me. We had five circular conversations about this . . . I just got disgusted." He finally decided to "fire" this physician. By overtly pathologizing Oberon, this provider communicated a belief that trans people are indeed mentally disordered and appeared to be unaware that this opinion was derogatory. Regardless of his intent, the messages he sent were microaggressive.

In addition to pathologization, participants encountered sexualization. Saulo, a southern European, transmasculine person in his early twenties, encountered sexualized, body-focused scrutiny when he shared his trans identity with his first therapist at age fourteen. He recalls, "She asked if I'd be willing to have a double mastectomy and if I needed a thing in between my legs to feel like a man." These questions were intrusive, aggressive, and communicated an assumption that trans people must have surgery. As cis people often do when they encounter trans individuals, the therapist here focused on sexual body parts, dehumanizing Saulo. The way she asked these questions, especially when referring to a penis as a "thing," indicates aversion to transition-related surgeries and male bodies, which Saulo sensed and interpreted as "bullying." Coming from a therapist, whose role it is to offer support, these remarks are particularly inappropriate. Feeling uncomfortable, halfway through the session, Saulo said that he wanted to stop the therapy and leave. Her response, "You're not going to evade the problem by leaving," was unsupportive and manipulative. She failed to see what the problem was in that moment for Saulo: the negative experience he was having with her. For her, the problem seemed to be that he was trans—a pathologizing perspective, which she communicated in her approach and attitude. This therapist also disclosed to Saulo's parents private information that Saulo had confidentially told her about his sexual identity and gender, thus unethically denying his privacy and communicating that he was not important enough to deserve professional discretion.

It is in some way not surprising that Oberon and Saulo experienced these microaggressions. For more than half a century, the main guidebooks for mental health practitioners pathologized and hypersexualized trans people.

Furthermore, the process of seeking gender-confirming health care and/or sex reclassification authorizes mental health professionals and administrators to determine if and how a trans person is "real." Nevertheless, the cultural context does not excuse microaggressive behavior. It does, however, offer insights into the roots of the problems and why they manifest, despite the good intentions of individual practitioners.

Shock, Awkwardness, and Avoidance

Another pattern of trans-specific microaggressions include behaviors and messages that communicate opinions that a trans person is a freak, oddity, or impossible subject. Serano (2007) contends that the media and certain "feminisms" play a large role in maintaining these dehumanizing perceptions of trans people. In general, media sensationalize how trans people perform gender, fixating attention on trans women. Two main archetypes of trans women consistently appear in mainstream media: the "pathetic transsexual," who is not recognized as a woman, and the "deceptive transsexual," who villainously betrays people by hiding her trans status until her dramatic reveal at the climax of the story (Serano, pp. 36–37). Both are depicted as "freaks" and neither as a "real" woman. Similarly, some "feminist" representations of trans women that appeared in the late 1970s and continue to appear today characterize them as "dupes of gender," "technologies of patriarchy," and "rapists" (see Serano). Aside from the dehumanizing depictions of trans feminine people, there are even fewer portrayals of genderqueer, gender nonconforming, and trans masculine people in mainstream media. If providers have limited exposure to trans people and their bodies, their perceptions will be heavily shaped by these cultural representations of trans people as artificial, as freaks, and as less than human. Many of our interviewees experienced their medical providers as shocked, avoidant, and generally awkward. These responses are likely due to unfamiliarity with trans people or internalized transphobic ideas.

Diamond, a white trans man in his mid-thirties, had a negative experience with a nurse after his hysterectomy procedure. "She [the nurse] was really awkward. She wouldn't even look at my parts properly when she had to put in a catheter . . . She looked close enough to know where to put it, but then looked away," he said. "It felt like she was avoiding being around me . . . I could just pick up on this vibe that she didn't feel comfortable around me." In avoiding looking at or interacting with Diamond, the nurse distanced herself from him. This was microaggressive, as it communicated a denigrating message that Diamond's body disturbed her. Her avoidance prevented her from doing her job competently and brought about stress, alarm, and fear

in Diamond, who was dependent on her as a caregiver. "It was really scary because I needed her full attention. At the same time, I didn't want her up in my business, but she had to be, to put in a catheter. There was no way around it." In this situation, Diamond had to overcompensate for the nurse's neglect and demand that she maintain a gaze with his genitals in order to properly place the catheter. "I had to tell her, 'You need to look at my parts,'" he recalled. Because of the way the nurse treated him, Diamond left the hospital earlier than he was supposed to, which limited him from getting all the post-operative care he needed at that facility.

Social distancing is a common experience for trans patients, and in many cases, it has great impact. Like Diamond, Eli, a light-skinned African American trans man in his early forties, saw a doctor who became shocked and distracted when he learned of Eli's trans identity. Eli had recently undergone a phalloplasty (surgical construction of a penis) outside the United States and had approached a different doctor when he needed follow-up surgery after returning to the United States. Eli characterized the doctor as initially "friendly," "engaging," and "not hurried." However, when Eli told the doctor about his phalloplasty, the doctor's demeanor, tone, and body language immediately changed. Eli's surgeon acted shocked and suddenly became curt. Eli said, "All of a sudden, his answers to my questions became monosyllabic, one-word answers. A couple seconds later, he rushes out of the room and is preparing an operating room for me to go." This dramatic affective shift from warmth to coldness sent a microaggressive message to Eli that his trans body was alarming to the surgeon. According to Eli, the doctor's shock distracted him to the point of impairing his ability to focus, resulting in a failed surgery, which negatively impacted Eli's emotional and bodily health. Stated Eli, "His attitude shifted toward me, and that affected the kind of care [he gave]. . . . He did a fucked-up job, and botched [the follow-up surgery] . . . I still have problems." Eli's experience is embedded in larger structural issues affecting trans health care. With only a handful of doctors internationally who are trained in urology and plastic surgery, and who are also trans-affirming, Eli's return to the United States left him with no choice for a surgical follow-up other than to see his HMO's doctors and endure both microaggressions and bodily harm.

Diamond's and Eli's providers treated them as repugnant freaks and less than human. Not only did the microaggressions emotionally impact each of them but they were also concurrent with medical neglect, harm, and in the case of Diamond, a lapse in care from leaving the hospital before his surgical recovery had sufficiently advanced. Larger cultural factors inform this pattern of awkwardness, shock, and avoidance. Dehumanizing representations of and sheer invisibility of trans people contribute to the attitudes, perceptions, and behaviors that practitioners bring into the health care setting.

Invalidation, Misgendering, and Exposure

A cissexist culture renders trans people unqualified to authenticate their own sex and gender identity, especially in cases where their trans status is made known (Kelly, 2012). As we mentioned, laws hold that a medical professional or administrator must authenticate a trans person's gender in order for that individual to acquire gender-confirming health care or sex reclassification in their identity documentation. Because of this legal arrangement, individuals and social systems may treat a trans person's self-identification as fake, unimportant, or fraudulent. In health care contexts where records may contain one's sex assigned at birth or a previous name, providers may address trans patients by a former name and/or inaccurate pronoun, misgendering them. Legitimating a cis person's designation of a trans person's gender over their own is a manifestation of cissexual gender entitlement (Serano, 2007). We also consider it a microaggression.

Sally, a white trans woman in her fifties, observed an instance of misgendering when she took her roommate, also a trans woman, to the hospital:

> Her doctor (who was my doctor for a while; this is one of the things that prompted me to change doctors) and almost everyone in the hospital staff referred to her as "he," kept calling Sarah by Sarah's original legal name, which, granted, it's in the medical file somewhere—but that file should have been updated ten years ago when she transitioned and had her surgery, you know, went through, did all the legal name change and everything. That all should have been changed and she should be referred to as "she"/ Sarah.

Calling Sarah by her former name and "he" are microaggressions because they invalidate her gender and indicate that the providers think her identity is not real or worthy of respect, or that their interpretation of her identity is *more valid* than her own. Sarah's case illustrates how administrative health care systems and groups of health care workers alike disrespect trans patients by continuing to identify them by their old names and pronouns, even after they have reclassified their sex on identity documents and records. In addition, hospital staff authorized and validated each other's misgenderings (a group microaggression), bolstering cissexist ideas that trans identities are inauthentic. Observing and receiving this repeated insult so upset Sally that she found a different doctor. This illustrates how misgendering burdens trans people by compelling them to choose between enduring a microaggressive environment or putting in the time and effort to find a new provider.

Identity invalidations can also lead to further invalidations when patients point out misgendering mistakes, illustrating how microaggressions can be multitiered. Sally related: "I asked the doc about it once and he said, 'Oh,

it's just a habit.' But he didn't take note of it and continued to call [Sarah] 'he.' And that was when I started noticing that everyone else that was dealing with her calls her 'he.' And I said something about it to Sarah, and she said, 'I asked about it a long time ago, and they can't seem to get their head wrapped around it.'" Here, when Sally and Sarah raised the issue, instead of recognizing their errors, apologizing, and correcting themselves, the health care providers dismissed the complaints and continued to misgender Sarah. This is a secondary microaggression, in addition to the original one. The initial misgendering invalidated Sarah's identity, and the secondary actions swept the first insult under the rug, ignoring and invalidating both her identity and her repeated attempts at recognition. It sent an underlying message that the health care providers did not care about or respect Sarah. Sally declared, "Some will and some won't [get it]. The ones that won't, I get my business done and go deal with somebody else. Like the doc in the hospital. Unless I get hurt right outside that hospital, I will ask to be taken elsewhere." To avoid disrespectful treatment, Sally has decided not to return to certain health care establishments where providers misgender her.

In addition to this kind of misgendering, invalidations can happen when health care providers fail to acknowledge gender identities and experiences beyond the categories of man and woman or male and female. Many trans individuals experience their gender identity as outside of this binary framework. Red, who is in their late twenties, identifies as half Thai, half white, "gender non-conforming," "trans," and "genderqueer, sort of." Red goes by the pronoun "they" rather than "he" or "she." When health care providers approach their interactions with patients from a cis-normative lens, recognizing only two genders, they invalidate the experiences of those who identify as neither man nor woman, or as a different gender entirely. Red underwent such an experience from a health care provider who regularly treated trans patients:

> There seems to be a "you're a transguy" thing. They [have] . . . this kind of expectation that I want to pass as male. Sometimes I go in to a new doctor and they assume, they use the word "transguy," but to me it feels like, "oh . . . you're in the beginning of your transition." I talked to a trans doctor and it felt like he was like, "Here's the whole thing and you become a transguy with a trans doctor at [this clinic]." . . . You arrive somewhere; he totally did a map thing: "You're driving from here to [the nearby city]." That's not how I feel about [my gender]. Or like, [saying] "I've talked to other transguys" feels like homogenization of what [transguy] is.

For Red, who does not identify as a transguy, being pigeonholed into the category feels invalidating. The provider is using words and metaphors that depict a unilateral or trajectory transition model, which does not resonate with Red's

experience or their health care needs. The health care providers place their conception of a "transguy" onto Red and dismiss Red's conceptualization of their own body, identity, and experience. Further, the providers attempted to channel Red into a monolithic one-size-fits-all transition route. This kind of routing takes shape in hormone prescription conventions. Red relates: "At [the clinic] someone called me, and they were like, 'your [testosterone] levels are too low, so we recommend that you should up your dose.'" Upping the dose would make Red's body appear more male, which they had previously communicated to the clinic providers that they do not want. By recommending a dosage increase, the providers appear to either not understand or to actively ignore Red's identity. Although this routing may be validating to some transmasculine people, for Red it is microaggressive because it invalidates their identity and experience of reality. Paradoxically, in a setting designed for Red to acquire gender-confirming health care, providers ignore Red's gender and harm their wellbeing. Binary ways of understanding gender and narrow, prescriptive ways of diagnosing and treating "GID" thus constrain Red's doctors' abilities to treat them appropriately both medically and interactively.

Misgendering also exposes trans patients' private information and puts them at risk of further microaggressions or victimization from others. Jack, a white trans male in his early twenties, claimed that one of the last times he went to his university's health center he "freaked out" at some of the staff because they kept calling him by his former name, Jackie: "It was awkward for me with everyone in the waiting room, having a person call me [by my birth name] . . . so I'll be having a conversation . . . then it's like, 'All right Jackie?' And [the other patients are] just like, 'Who?' . . . it felt like . . . *unwelcomed exposure*" [emphasis added]. The public exposure of Jack's birth name in this context was a microaggression that sent a meta-communication that his privacy was not important and that his self-identification was not valid enough to use when addressing him. This microaggression was both systemic and interpersonal, as neither the administrative health care system nor the health care worker accurately accounted for his gender identity. This misgendering also increased the possibility that others might call his gender identity into question or invalidate it. Jack said that he felt "pissed off" for being put in a position where he had to manage a social interaction around his identity, which he did not want to discuss with casual acquaintances. As Jack laments, these experiences of exposure often lead others to inquire about his identity and ask him to account for the discontinuities between his documented gender and presentation of self. These kinds of intrusive questions are additional microaggressions, communicating that Jack's privacy is not important and that he must explain his gender identity to cis people.

Invalidation, misgendering, and exposure are microaggressions that stem from legal, medical, and social systems, policies, and practices that delegate cis people (especially staff and administrators) and not trans people as identity authorities. Despite acts of self- and community-advocacy, we see from Sally, Sarah, Red, and Jack how microaggressions impact trans people, often to the extent that they turn away from health care systems. Leaving health care systems in the midst of treatment or altogether negatively impacts trans people's health and limits their access to care.

Intrusion, Coercion, and Isolation

Trans people face a particular kind of coercion and violence in mental health care institutional contexts. In the context of a culture that imagines trans people to be unreal, fake, pathological, and deceptive, mental health care settings can be a particularly dangerous place for trans people. The "deceptive" stereotype manifests substantial impacts when it brings about preemptive and reactive behavior in mental health care workers. This stereotype translates to inaccurate perceptions that trans people are "being manipulative" to "get what they want" (e.g., to get gender-confirming care) and problematic responses, like the idea that mental health care providers should punish trans people for this "behavior." This approach invalidates trans individuals' realities and disciplines them for (healthily) being true to themselves. Similarly, providers can perceive self-advocacy as insubordination, which can lead them to abuse trans clients under the guise of "correcting bad behavior." As we illustrate, rather than trans patients' behavior, the cis-normative, cissexist administrative health care system is the true problem.

Marie, a white trans woman in her forties, encountered misgendering in a hospital's psychiatric ward. When Marie arrived at the hospital, the nurses asked what name she would like to be called but continued to address her by her former (man's) name and "he" and placed her in a gender-segregated room with a man. By asking what name she preferred, the nurses indicated that they were aware of appropriate ways to treat trans patients with respect. Then, they knowingly disrespected Marie, using her old name and pronouns, and placed her in a room with a man, invalidating and dismissing her. These actions sent a meta-communication of disapproval of her transness and also exposed her trans identity to other patients and providers, which denied her right to privacy and increased her vulnerability to further trans-specific targeting.

In addition, in the context of a psychiatric facility, as Marie explains, there are potential consequences for correcting misgendering: "Anything you

do is interpreted as a sign of psychosis of some sort. . . . When they're calling me the wrong name, if I correct them, they might toss me in the room and strap me down and shoot me up with Ativan. So is it worth it to make a confrontation? Do I have the mental energy to deal with it? I didn't, so I let it go. It really bothered me the whole time I was there." This procedure is designed to be coercive. Marie faces great *administratively mandated* risks (physical restraint and forced drugging) if she corrects misgendering and reminds others how to address her. To understate the problem, this scenario is insufficient in terms of mental health care. It actually exacerbates Marie's stress and limits her access to either internal or external emotional health resources. Marie is afraid of the consequences, so she opts to forgo advocating for herself. She cannot access adequate health care because she faces microaggressions and discipline as medical institutionalizations of cisgender normativity.

Administrative inadequacies in health care manifest in many other ways as well. Myke, a white trans man in his early thirties, supported by disability, had spent time in detox and chemical dependency rehabilitation facilities prior to as well as throughout his transition. Whenever Myke was hospitalized or entered a treatment center, health care workers placed him in a single room and denied him the opportunity to share a room with other men. Myke identified as "male, but not completely," had taken testosterone for over a year, and had undergone chest surgery but had not changed the sex marker on his identity documents or records to "M." Though he appeared male, as his medical records listed him as "female," staff refused to allow Myke to room with men or women, thus segregating Myke from all other patients. In one instance of an overcrowded facility, providers housed Myke in the "quiet room," which they usually used to isolate "unruly" patients. They did not place Myke in this room at other patients' requests but to meet administrative demands and protocol for sex segregation. Administrators may have feared that the facility would be liable if a cis male roommate assaulted or harassed Myke. However, this reasoning prioritizes the welfare of the institution or facility over the safety and wellbeing of patients. Isolating Myke was an administratively coordinated microaggression, which sent a message to him that he did not belong and that his presence alone was equivalent to a behavioral problem.

The circumstance discussed above was not Myke's only experience with exclusionary treatment by medical personnel. Another time, hospital staff sent Myke to a detox and rehabilitation center where the ward had been split into a women's side and a men's side in response to increased incidences of male patients harassing female patients. Upon noting the incongruence between Myke's appearance and medical records, the staff refused to house Myke in this facility. He describes:

> They look at my name and then they look at me and they look at the chart and they're like, "We're confused, I thought you were a girl." And I'm like, "Well, I have girl parts but I'm a guy . . . so, put me on the men's side." And they're like, "Well, we can't do that because you have a vagina." . . . "You're going to put me on the women's side?" And they're like, "Well, I don't know yet." . . . The room was split down the middle by a piece of tape and they put me in a chair with the tape in the middle so I was literally on both sides and they had me wait there for an hour.

This action invalidated Myke's gender identity, made him a spectacle, publicly humiliated him, and sent a message that he was a problem. In fact, the gender-segregated, cis-normative system was the problem, as it was not adequately designed to provide care for trans patients and thus resulted in misgendering and marginalization. After the hour wait, they transferred Myke to a different facility and placed him in a single room with a private bathroom and shower.

During a different experience in a rehab facility, staff members were aware of Myke's trans status and again housed him in a single room, isolating him for a third time. The night staff locked the only single unit bathroom on the ward, told Myke that he had to use the women's bathroom, and threatened to physically restrain Myke if he tried to use the men's. These actions deliberately intimidated Myke and communicated deeper messages that he was unimportant and did not deserve access to an appropriate, safe bathroom. They also knowingly and deliberately invalidated his gender identity and cornered him into a no-win situation. Myke refused to use the women's bathroom: "Women in a hospital should not have men in their bathroom. Any man, trans or [not]. . . . They're going through traumatic experiences and . . . it's not fair to them to have a man in their bathroom. . . . I was not willing to put women in that situation. . . . And the men didn't care that I was in their bathroom. . . .So, I used the men's room anyway and I did get restrained." Essentially, hospital staff physically abused Myke for his gender subversion. In each of these experiences, Myke actively declined using women's facilities in order to meet what he perceived female patients needed and to affirm his "male . . . leaning" identity. When Myke was asked whether he reported this abuse to hospital administrators, he said: "Well, I tried, let's put it that way . . . it's complicated. I got punched by a nurse just for staring at them, and I punched him back . . . and I got nearly beaten to death. . . . And like, they put a towel over my face and kind of suffocated me and it was bad. So, I, I don't bring it up." In this setting, where he is dependent on hospital staff for his well-being, Myke encountered institutionalized physical and emotional abuse (what providers called "restraining" him) for being and behaving as himself, and further abuse when he nonverbally expressed discontent and when he

physically defended himself. Though these actions are overtly violent, they are also microaggressions because it is likely that the perpetrators do not see injustice in their actions. "I was mad because I'd been lied to and then treated like a weird thing that had to be put on a line," said Myke. After experiencing physical "restraint," isolation in single rooms, and the denigration of being placed on the line that separated a sex-segregated ward, Myke avoided hospitalization: "I haven't been in the hospital in about a year, which is the longest it's been for a long time. But I've realized . . . if I can figure out any other way to get through something, it's better than having to deal with that again." Though this demonstrates resourcefulness, avoiding health care systems limits Myke's access to care. Ultimately, cis-normative administrative procedures, structural forces, and interpersonal treatment combine in the medical space to downgrade Myke as a trans individual.

These microaggressions isolate, intrude on, and coerce trans people. They are the result of mutually reinforcing systems and ideologies that perpetuate inequities of authority and autonomy. Depending on health care systems that pathologize, punish, and invalidate them negatively impacts Marie and Myke. They are subjects of and subject to models of classification and care that render them vulnerable to maltreatment. Myke and Marie are further limited by their unemployment to seek out alternative facilities, practitioners, or approaches to treatment. For Myke, leaving the health care system could mean death as a result of drug addiction.

In sum, health care practitioners are paradoxically doing damage to the patients they treat. Providers treat trans people as pathological and sexualize their bodies. They behave awkwardly in the presence of trans people, if not outright avoiding interacting with trans people altogether. Health care practitioners expose and misgender trans people and invalidate their identities. They also coerce, intrude upon, and isolate trans patients. These microaggressions result in medical harm and neglect. To get through these situations, trans people either advocate for themselves, complain to higher-ups, attempt to educate their providers or find new ones, or contain their feelings. Some leave in the midst of treatment, perhaps never returning to the health care system again. Consequently, trans people experience fewer opportunities to obtain necessary medical care than cis people and institutionalized barriers to care within cis-normative health care systems, which exacerbate their health risks. The microaggressive interactions that health care practitioners have with trans patients are a contributing factor to this social phenomenon. As we have discussed, microaggressions are part of the larger structural problem of unequal access to healthcare. They occur in social contexts shaped by race, employment status, income, mental health status, and education. These factors also

influence the possibility that self-advocacy will lead to respectful treatment. It is only by addressing the interrelation of each of these issues that change can be made.

RECOMMENDATIONS FOR TRANS-ALLIED HEALTH CARE PRACTICE

What might health care administrators and practitioners do to improve trans people's access to adequate health care? The microaggressions trans people encounter are repetitive, prompt painful feelings, and accumulate in minority stress. As one interviewee, Eli, noted, these interactions have "a cumulative effect." He continued, "Surgeons don't want to help you when you tell them who you are. Sometimes I feel I can do it, sometimes I'm tired of it. I do it all the time in life. I'm a patient in the hospital just trying to get through it." Eli speaks here to the position he is often in of interacting with those who are unfamiliar with trans people. He feels exhausted from needing to educate others about his life. This necessity to educate providers is an unavoidable form of unpaid labor, and as most providers are unfamiliar with trans individuals, trans patients can expect to do this labor every time they go to the doctor. Repetitively having to explain oneself and deal with others' reactions creates a form of minority stress specific to the trans experience. So, health care practitioners should not rely on trans patients to be their educators. This is, in effect, another microaggression.

The problems that we have illustrated here stem from cis-normativity and cissexism as they manifest systemically and interpersonally. Like other forms of discrimination, microaggressions are informed and shaped by societal practices and cultural expectations. They are systemic, which means that irrespective of individual prejudice, people will still deliver them unless changes are made on a larger scale. Our cissexist culture defines sex and gender as binary and immutable, renders trans people monstrous, pathological, fake, and unable to authenticate their own sex and gender identities, and authorizes cis people to determine trans people's "real" genders. When these assumptions translate into behaviors, health care providers mistreat trans patients sending blatantly hostile messages and microaggressions, and thus negatively impacting their patients' health. In response to these mistreatments, some trans people leave providers or health care systems after or even during treatment. While some seek out other providers, others opt out of the formal health care system entirely. Our recommendations for better care come from acknowledging these components. Below we outline some concrete ways providers can address the root

causes of trans-specific microaggressions and work to develop more supportive health care practices.

1. Respect and Integrate Trans People's Identities

Trans people have been creating alternative ways to code gender, which depend neither on the sex assigned to them at birth, nor on an administrator's validation, but on their own internal sense of self. As Cromwell (1999) and Hale (1997) found, trans people recode and resignify bodies, so that intersubjective recognition can take place without bodily alterations. As recognition does not start and stop at the body, trans people have been creating ways to recognize each other. In many cases, they verbally communicate how they would like to be read and addressed, specifying their name and pronouns, and at times, they communicate how they identify their gender (Nordmarken, 2013).

Health care workers can follow their trans patients' lead, by authorizing them as legitimate knowers of their own identities and treating them as authorities and experts of their own experience. Providers can ask about and note their patients' stated names and pronouns and can address and treat them accordingly. In sex-segregated facilities, this might mean housing them with individuals of their identified gender, rather than with individuals of their assigned sex at birth.

Sex-segregation fundamentally creates problems for trans patients. Ideally, facilities should not sex-segregate their patients, but if segregation is necessary, they should offer trans patients the option of a separate location, ask trans patients where they would like to be and place them there. Despite popular notions, trans people are often welcomed by their cis peers into sex-segregated facilities, and their subsequent removal or exclusion may be driven by administrative mandate, not community demand (Kelly, 2012). As isolation has many negative psychological effects, providers should isolate a trans patient in a non-standard room only if the patient chooses it; they should never isolate a patient by force.

Making efforts to validate trans patients' identities may help avoid exposing their trans status and enacting other microaggressive behavior and may protect them from further targeting or discrimination. Administrators and policy makers can change procedures to facilitate administrative recognition, to streamline gender transitions (whatever their form), and to accommodate and validate trans self-definition and self-authentication. This might require thinking creatively in a nonbinary way about: how to revise intake and other forms and documents in order to record a variety of pronouns, gender identifications and the possibility for multiple changes in identification; how to include trans

people in support services and institutions; and how to provide resources and benefits to trans people, which they would otherwise be excluded from or refused on account of their gender illegibility.

2. Reflect On and Change One's Own Interpersonal Practices

In order to combat the cissexist ideologies and perceptions deeply embedded in contemporary American culture, it is critical to acknowledge our internalized prejudices and assumptions about trans people and become aware of the ways these manifest in our own interpersonal interactions. Beginning from the assumption that we all have internalized negative stereotypes and perceptions of trans people will aid in building awareness of how microaggressions manifest and decrease associated ignorance and possibly shame or resistance to change. Curiosity, constant vigilance, continuous observation, and reflection on our behavior will help us notice when we enact microaggressions. When health care providers recognize their active enactments of microaggressions, they will be able to question their own latent prejudices. Only then will they be able to interrupt their behavior and decide to pursue a different route of action.

3. Approach Care Provision with Sensitivity and as a Collaborative Effort with Patients

As it is likely that trans and gender nonconforming patients have had negative and possibly traumatic experiences in health care, they may be nervous or anticipate discomfort in any sort of encounter with providers. Providers who signal their awareness of these issues and their desire to make the experience a positive and healing one indicate that they care about their trans patients, which can help alleviate patient anxiety. Treating transness or bodily difference as a nonissue and working to not show or feel shock (even if providers react inside) is a good way to help trans patients feel seen as complete human beings and not as freaks in these vulnerable situations. Familiarizing oneself with trans people and culture, such as watching films made by trans people or reading books written by trans people, can help providers to understand and normalize transness for themselves, which can also help to allay their concern about interacting with trans patients. In addition, approaching health care practice creatively, with extra care, and as a collaborative effort will help make the experience better for patients. For example, asking permission to touch a patient's body, asking patients what terms they prefer to use for gendered and sexual body parts and using those terms, inviting patients to communicate if they feel uncomfortable, or inviting them to physically position themselves in

ways that feel more comfortable to them can help put patients at ease and stay mentally and emotionally present. Inviting communication and negotiation recognizes patients as experts of their own embodied experience and encourages patients to take active responsibility for their own health. If providers must do certain things in ways that patients do not prefer, providers can explain the reasons clearly and can communicate that they are keeping patients' best interests in mind.

4. Prioritize Trans Competency Trainings and Continuous Gender Diversity Education

As a majority of health care workers are unprepared to provide adequate care to trans patients, we need to make information about trans issues available to individuals working in the health care field and to prioritize this as a pressing competency issue. Because microaggressions are the active manifestation of unconscious prejudice and internalized stereotypes, some derogatory treatment might be avoided by introducing workers to information about trans people developed from trans-affirmative and advocacy-centered perspectives. Health care workers can organize and attend cultural competency trainings, trans speakers' bureau presentations, or educational film screenings in their workplaces. Introducing providers to information about providers' discrimination against trans people through the lens of microaggressions can be particularly useful, as it frames the issue as one of unawareness and makes visible the reality that all social actors deliver microaggressions. This may avoid shaming well-meaning microaggressors and may help them stay open to noticing, reflecting on, and changing their behavior.

Although professional development sessions are useful, they do not sufficiently engender trans competency. One or two trainings will probably not develop in providers an understanding of or familiarity with trans people, which, as we have demonstrated is likely to result in continued mistreatment, even when providers have the best intentions, and often even when they have expert knowledge. Some health care providers who have worked longer in the field likely received information about trans people during eras of heightened trans pathologization and may carry negative and harmful perceptions into their current practice. Therefore, what health care workers need to do is commit to ongoing education and exploration in order to familiarize themselves with trans people, develop an understanding of gender diversity and the multiplicity of gender identities, and identify the way that cis-normative sex and gender categories and expectations have shaped their own lives and how cissexism has shaped their perspectives on trans people.

5. Work Together to Change Workplace Culture

As teams of workers as well as individual providers collaboratively deliver and uphold microaggressive actions, colleagues can help each other understand microaggressions and administrative violence. They can model respectful treatment of trans patients; they can use patients' correct pronouns, gender identities, and names consistently in discussions and remind each other when they slip up; and they can offer information on trans people and the issues of inequality and injustice they face. Providers who are more aware can make affirming statements about their trans and gender nonconforming patients in front of other providers so they see that patients are not freaks or curiosities but real people they care about. They can work together to create better ways of administratively and interactively treating trans patients. Finally, they can create a shared language about microaggressions in the workplace to open up space to discuss the role oppression plays in health care provision and how they, as a community, might do things differently.

6. Develop Allyship Practices

In addition to acknowledging trans people's identities, increasing awareness about microaggressions, and changing how they perceive and treat trans people, it is similarly important for health care providers to acknowledge their role in the hierarchy of identity validation. Often referred to as "gatekeeper," health care professionals are positioned as the arbiters of authenticating a trans person's identity and procuring access to gender confirming health care and a legal sex reclassification. Providers need to question their own authority in this role and think creatively about how they might rearrange how they approach their work in order to recognize trans individuals' epistemic authority. Until we dismantle this hierarchy of identity authorization, health care professionals can use their privilege to honor trans patients' needs and advocate on their behalf.

7. Suggest and Create Policy Changes

Recognizing and changing microaggressive health care spaces are imperative to cultural change, but they do little to work against larger structural problems. Policy changes have more weight to do that. Health care providers and administrators can get involved in making changes where they have influence and beyond. Administrators in public and private health care milieu can make sure internal policies support trans patients. Specifically, health insurance companies can change their policies to cover transition-related health

care. As Spade (2011) suggests, alleviating medical changes required for legal gender change would make transition much more accessible. This would also help trans people access medical care, because they could more easily obtain accurate identity documents. Developing creative ways to signify pronouns, sexed characteristics, and genders on identity documents is one idea for how to resolve the problem of the current limited, binary "M-F" requirement, which makes invisible the multiplicity and complexities of trans people's bodies and identities. To transform larger structural problems, ramping up the welfare state, socializing health care, developing social programs for trans individuals, and dismantling prison and detention systems would improve trans people's physical and emotional health.

For further resources and guides on policy recommendations, see:

National Center for Transgender Equality: http://transequality.org/
Human Rights Campaign: http://www.hrc.org/resources/entry/transgender-inclusive-benefits-for-employees-and-dependents